Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VAMC Huntington, WV - 581

VISN 9

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 85

2. Point-in-time estimate of Veterans who are Chronically Homeless: 11

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **85** (point-in-time estimate of homeless veterans in service area) **X 19%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 65%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 11** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	240	0
Transitional Housing Beds	50	20
Permanent Housing Beds	6	50

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 2

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	VA Healthcare for Homeless Veterans staff will continue to work with local coalitions and housing authorities to address long-term permanent housing concerns.
Transitional living facility	Veterans of Vietnam War, Inc., are in process of establishing Beacon House transitional living facility in Huntington, WV. A building has been secured and renovations are in progress. Per initial contacts between Beacon House and VAMC, is projected that VA MHC/SATP and VA Healthcare for Homeless Veterans staff will play a significant role in referral, placement, and post-placement follow-up process.
Services for emotional or psychiatric problems	IP Psych services within Huntington PSA remain "status quo." Huntington VAMC does not have inpatient unit. Veteran needing acute IP care referred to other VAMC or WV Dept. of Mental Health Hospital System. Outpatient MH will expand by adding social work position at Charleston WV CBOC and increasing role of social worker at Prestonsburg KY CBOC. Continue to work with ERA (Engagement, Rehabilitation, Aftercare), a CSAT-funded treatment program for homeless.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 29 Non-VA staff Participants: 76% Homeless/Formerly Homeless: 10%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Halfway house or transitional living facility	2.39	43%	2.76	8
2	Long-term, permanent housing	2.52	36%	2.25	1
3	Detoxification from substances	2.57	14%	3.11	22
4	Child care	2.67	0%	2.39	3
5	Dental care	2.76	4%	2.34	2
6	Treatment for substance abuse	2.79	14%	3.30	28
7	Treatment for dual diagnosis	2.79	7%	3.01	18
8	Family counseling	2.79	7%	2.85	12
9	Services for emotional or psychiatric problems	2.86	25%	3.20	25
10	Eye care	2.97	4%	2.65	5
11	Glasses	2.97	0%	2.67	6
12	Help managing money	3.03	0%	2.71	7
13	Legal assistance	3.07	0%	2.61	4
14	Personal hygiene (shower, haircut, etc.)	3.14	0%	3.21	26
15	Help with medication	3.14	0%	3.18	24
16	Job training	3.18	0%	2.88	14
17	Discharge upgrade	3.22	0%	2.90	15
18	Guardianship (financial)	3.28	4%	2.76	9
19	Drop-in center or day program	3.29	0%	2.77	10
20	Help with finding a job or getting employment	3.31	11%	3.00	17
21	Help with transportation	3.31	0%	2.82	11
22	Welfare payments	3.33	0%	2.97	16
23	Education	3.34	0%	2.88	13
24	AIDS/HIV testing/counseling	3.38	0%	3.38	30
25	Women's health care	3.39	0%	3.09	21
26	Hepatitis C testing	3.45	0%	3.41	32
27	SSI/SSD process	3.48	4%	3.02	19
28	TB treatment	3.52	0%	3.45	33
29	Medical services	3.55	4%	3.55	34
30	VA disability/pension	3.59	4%	3.33	29
31	Help getting needed documents or identification	3.59	0%	3.16	23
32	Spiritual	3.59	4%	3.30	27
33	Clothing	3.62	4%	3.40	31
34	TB testing	3.69	0%	3.58	36
35	Emergency (immediate) shelter	3.7	4%	3.04	20
36	Food	3.72	7%	3.56	35

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.11	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.25	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.59	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.31	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.66	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.1	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.55	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.62	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.26	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	1.7	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.73	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.27	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.55	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.14	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.32	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.59	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.27	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.23	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.43	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.41	1.84

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VAMC Lexington, KY - 596

VISN 9

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 50

2. Point-in-time estimate of Veterans who are Chronically Homeless: <DATA NOT AVAILABLE>

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **50** (point-in-time estimate of homeless veterans in service area) **X <DATA NOT AVAILABLE>%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X <DATA NOT AVAILABLE>%** (percentage of veterans served who had a mental health or substance abuse disorder) **= <DATA NOT AVAILABLE>** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	170	0
Transitional Housing Beds	120	50
Permanent Housing Beds	20	0

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 2

3. CHALENG Point of Contact Action Plan for FY 2005

Transitional living facility	Work with homeless veterans transitional living facility to be opened in January 2005 at our Leestown Road facility. This will be a 40-bed unit.
Services for emotional or psychiatric problems	Work on increasing the number of mental health Center (VAMC) referrals.
Other	Work on an increase in the current social work staffing available from the current .20 FTEE to at least .5 to .75 FTEE for VAMC homeless programs.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 11 Non-VA staff Participants: 82% Homeless/Formerly Homeless: 45%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Dental care	2.4	50%	2.34	2
2	Welfare payments	2.44	10%	2.97	16
3	Women's health care	2.71	0%	3.09	21
4	Long-term, permanent housing	2.73	10%	2.25	1
5	Help managing money	2.89	0%	2.71	7
6	Family counseling	2.9	0%	2.85	12
7	Glasses	2.9	0%	2.67	6
8	Spiritual	3	0%	3.30	27
9	Hepatitis C testing	3.1	0%	3.41	32
10	Eye care	3.1	30%	2.65	5
11	Guardianship (financial)	3.1	0%	2.76	9
12	Job training	3.11	0%	2.88	14
13	Child care	3.14	0%	2.39	3
14	SSI/SSD process	3.25	10%	3.02	19
15	Halfway house or transitional living facility	3.36	10%	2.76	8
16	Help with finding a job or getting employment	3.44	0%	3.00	17
17	Education	3.44	0%	2.88	13
18	Discharge upgrade	3.5	0%	2.90	15
19	Detoxification from substances	3.55	0%	3.11	22
20	AIDS/HIV testing/counseling	3.6	0%	3.38	30
21	Legal assistance	3.63	0%	2.61	4
22	Treatment for dual diagnosis	3.64	0%	3.01	18
23	Help getting needed documents or identification	3.67	0%	3.16	23
24	Drop-in center or day program	3.8	0%	2.77	10
25	VA disability/pension	3.8	30%	3.33	29
26	Emergency (immediate) shelter	3.82	20%	3.04	20
27	Treatment for substance abuse	3.82	10%	3.30	28
28	Help with transportation	3.9	10%	2.82	11
29	Personal hygiene (shower, haircut, etc.)	3.91	0%	3.21	26
30	Food	4.09	0%	3.56	35
31	Services for emotional or psychiatric problems	4.09	0%	3.20	25
32	Clothing	4.45	0%	3.40	31
33	TB treatment	4.5	0%	3.45	33
34	TB testing	4.55	0%	3.58	36
35	Help with medication	4.56	0%	3.18	24
36	Medical services	4.82	10%	3.55	34

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.64	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.45	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.82	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4.09	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4.18	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	4.27	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.2	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	3	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.6	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	3.18	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.45	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.82	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.7	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.55	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.64	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.9	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.4	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.55	1.84

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VAMC Louisville, KY - 603

VISN 9

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 1000

2. Point-in-time estimate of Veterans who are Chronically Homeless: 181

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **1000** (point-in-time estimate of homeless veterans in service area) **X 21%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 85%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 181** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	725	50
Transitional Housing Beds	564	50
Permanent Housing Beds	421	60

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Informal agreements with HUD Shelter Plus Care and Louisville Metro Human Services has increased homeless veteran opportunities for permanent housing.
Transitional living facility	Transitional housing continues to be needed and efforts are ongoing to obtain it.
Services for emotional or psychiatric problems	Continue to identify veterans in community needing services for emotional or psychiatric problems. Education to identify those in need will continue in shelters and outreach communities. Use of existing agencies will continue to serve veterans' needs.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 21 Non-VA staff Participants: 81%
Homeless/Formerly Homeless: 5%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	2	44%	2.25	1
2	Help managing money	2.35	6%	2.71	7
3	Services for emotional or psychiatric problems	2.38	17%	3.20	25
4	Treatment for dual diagnosis	2.48	0%	3.01	18
5	Help with finding a job or getting employment	2.48	16%	3.00	17
6	Child care	2.53	0%	2.39	3
7	Job training	2.57	11%	2.88	14
8	Guardianship (financial)	2.6	6%	2.76	9
9	Family counseling	2.62	0%	2.85	12
10	Help with medication	2.62	0%	3.18	24
11	Eye care	2.62	0%	2.65	5
12	Treatment for substance abuse	2.67	22%	3.30	28
13	Dental care	2.67	0%	2.34	2
14	Glasses	2.71	0%	2.67	6
15	Help with transportation	2.74	11%	2.82	11
16	Legal assistance	2.75	6%	2.61	4
17	Education	2.8	0%	2.88	13
18	Welfare payments	2.85	0%	2.97	16
19	Halfway house or transitional living facility	2.86	28%	2.76	8
20	Drop-in center or day program	2.9	0%	2.77	10
21	Detoxification from substances	2.95	17%	3.11	22
22	SSI/SSD process	3	0%	3.02	19
23	Women's health care	3.05	0%	3.09	21
24	Help getting needed documents or identification	3.26	0%	3.16	23
25	Hepatitis C testing	3.3	0%	3.41	32
26	Spiritual	3.32	0%	3.30	27
27	AIDS/HIV testing/counseling	3.33	0%	3.38	30
28	Discharge upgrade	3.37	0%	2.90	15
29	Medical services	3.38	0%	3.55	34
30	Emergency (immediate) shelter	3.48	11%	3.04	20
31	TB treatment	3.48	0%	3.45	33
32	VA disability/pension	3.67	6%	3.33	29
33	Personal hygiene (shower, haircut, etc.)	3.7	0%	3.21	26
34	Clothing	3.71	0%	3.40	31
35	TB testing	3.76	0%	3.58	36
36	Food	3.86	6%	3.56	35

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.81	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.71	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.4	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.1	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4.05	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4.2	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.76	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.88	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	3.24	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.44	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	3	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.25	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.94	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.25	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	3.13	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.41	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.94	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.25	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.19	1.84

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VAMC Memphis, TN - 614

VISN 9

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 1312

2. Point-in-time estimate of Veterans who are Chronically Homeless: 231

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **1312** (point-in-time estimate of homeless veterans in service area) **X 19%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 91%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 231** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	120	0
Transitional Housing Beds	126	0
Permanent Housing Beds	35	30

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 2

3. CHALENG Point of Contact Action Plan for FY 2005

Eye Care	Most homeless veterans are not eligible for eye care. Community resources are limited. University of Tennessee School of Optometry is able to serve some of our veterans (eye exams).
Glasses	Limited resources for prescription glasses for individuals with minimal financial resources.
Help with Transportation	Most veterans are needing additional assistance during the early stages (generally 2-3 weeks) of transitional housing for travel to community resources for school, job interviews, etc. Periodically, local public transportation will donate bus tickets.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 20 Non-VA staff Participants: 95%
Homeless/Formerly Homeless: 0%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Legal assistance	2.57	7%	2.61	4
2	Family counseling	2.67	0%	2.85	12
3	Child care	2.67	0%	2.39	3
4	Dental care	2.73	20%	2.34	2
5	Help managing money	2.75	0%	2.71	7
6	Job training	2.81	20%	2.88	14
7	Long-term, permanent housing	2.82	13%	2.25	1
8	Personal hygiene (shower, haircut, etc.)	2.88	7%	3.21	26
9	Treatment for dual diagnosis	3	0%	3.01	18
10	Help with finding a job or getting employment	3	20%	3.00	17
11	Emergency (immediate) shelter	3.07	0%	3.04	20
12	Help with transportation	3.07	7%	2.82	11
13	Halfway house or transitional living facility	3.13	13%	2.76	8
14	Eye care	3.14	0%	2.65	5
15	Help with medication	3.19	7%	3.18	24
16	Clothing	3.2	7%	3.40	31
17	Glasses	3.2	0%	2.67	6
18	Education	3.2	0%	2.88	13
19	Guardianship (financial)	3.21	0%	2.76	9
20	Discharge upgrade	3.23	0%	2.90	15
21	Services for emotional or psychiatric problems	3.27	33%	3.20	25
22	Drop-in center or day program	3.27	0%	2.77	10
23	Spiritual	3.27	20%	3.30	27
24	Food	3.33	13%	3.56	35
25	VA disability/pension	3.38	0%	3.33	29
26	Welfare payments	3.38	0%	2.97	16
27	TB testing	3.4	0%	3.58	36
28	Help getting needed documents or identification	3.4	0%	3.16	23
29	Treatment for substance abuse	3.47	7%	3.30	28
30	Detoxification from substances	3.5	7%	3.11	22
31	AIDS/HIV testing/counseling	3.53	0%	3.38	30
32	Hepatitis C testing	3.57	0%	3.41	32
33	SSI/SSD process	3.57	0%	3.02	19
34	Women's health care	3.67	0%	3.09	21
35	TB treatment	3.67	0%	3.45	33
36	Medical services	3.73	13%	3.55	34

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.53	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.28	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.31	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	3.88	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.41	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.83	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.21	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.06	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	1.35	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.53	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.94	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.56	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.47	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.41	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.88	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.35	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.56	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.56	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.5	1.84

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VAMC Mountain Home, TN - 621

VISN 9

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 650

2. Point-in-time estimate of Veterans who are Chronically Homeless: 183

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **650** (point-in-time estimate of homeless veterans in service area) **X 32%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 89%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 183** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	250	25
Transitional Housing Beds	83	20
Permanent Housing Beds	6	100

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 5

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Work closely with eight county coalitions (HUD Continuum) to develop 30-bed facility. Community has offered financing for renovation.
Transitional living facility	Memorandum of agreement with Kingsport Housing Authority to place and provide supportive services for a portion of 22 HUD Shelter Plus Care beds.
Drop-in Center or Day Program	Day Center has been developed by local faith-based organization (Good Samaritan) in conjunction with local homeless coalition. The building is ready but not staffed. Project on hold during major effort to develop HUD Shelter Plus Care program.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 17 Non-VA staff Participants: 76% Homeless/Formerly Homeless: 18%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	2.27	38%	2.25	1
2	Child care	2.33	0%	2.39	3
3	Drop-in center or day program	2.35	20%	2.77	10
4	Halfway house or transitional living facility	2.47	53%	2.76	8
5	Help managing money	2.47	0%	2.71	7
6	Eye care	2.53	0%	2.65	5
7	Legal assistance	2.6	0%	2.61	4
8	Guardianship (financial)	2.63	0%	2.76	9
9	Job training	2.65	7%	2.88	14
10	Help with finding a job or getting employment	2.65	0%	3.00	17
11	Dental care	2.71	7%	2.34	2
12	Help getting needed documents or identification	2.81	7%	3.16	23
13	Glasses	2.82	0%	2.67	6
14	Education	2.82	0%	2.88	13
15	Detoxification from substances	2.88	0%	3.11	22
16	Help with medication	2.88	13%	3.18	24
17	Help with transportation	2.88	7%	2.82	11
18	Family counseling	3.12	0%	2.85	12
19	Treatment for dual diagnosis	3.13	0%	3.01	18
20	AIDS/HIV testing/counseling	3.24	0%	3.38	30
21	Welfare payments	3.27	0%	2.97	16
22	Treatment for substance abuse	3.29	7%	3.30	28
23	Services for emotional or psychiatric problems	3.35	0%	3.20	25
24	SSI/SSD process	3.38	0%	3.02	19
25	TB treatment	3.41	0%	3.45	33
26	Discharge upgrade	3.43	0%	2.90	15
27	Hepatitis C testing	3.44	0%	3.41	32
28	TB testing	3.47	0%	3.58	36
29	Personal hygiene (shower, haircut, etc.)	3.53	0%	3.21	26
30	Women's health care	3.53	0%	3.09	21
31	Spiritual	3.65	7%	3.30	27
32	Emergency (immediate) shelter	3.82	20%	3.04	20
33	VA disability/pension	3.94	0%	3.33	29
34	Clothing	4	7%	3.40	31
35	Medical services	4.06	0%	3.55	34
36	Food	4.12	13%	3.56	35

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	4.53	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.82	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.71	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.65	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4.76	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.71	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4.53	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	4.41	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.93	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.14	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.92	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.62	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.85	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.54	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.54	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.92	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	2.15	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.85	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.92	1.84

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VAMC Nashville, TN - 626 (Nashville and Murfreesboro)

VISN 9

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 175

2. Point-in-time estimate of Veterans who are Chronically Homeless: 48

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **175** (point-in-time estimate of homeless veterans in service area) **X 29%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 94%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 48** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	546	80
Transitional Housing Beds	100	50
Permanent Housing Beds	60	25

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 4

3. CHALENG Point of Contact Action Plan for FY 2005

Transitional living facility	The VA Healthcare for Homeless Veterans team will continue to educate and inform community providers of the VA Grant and Per Diem program, homeless web sites though GAPS, Mayors Task Force, and coalition meetings.
Detoxification from substances	VA Healthcare for Homeless Veterans social workers will continue to work closely with VA Substance Abuse Treatment Program and community providers -- and educate veterans of resources in VA and middle Tennessee area.
Treatment for substance abuse	VA Healthcare for Homeless Veterans will continue to work closely with Substance Abuse Treatment Program and will access all community provider services.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 4 Non-VA staff Participants: 100% Homeless/Formerly Homeless: 25%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Eye care	1.5	0%	2.65	5
2	Child care	1.5	0%	2.39	3
3	Dental care	1.75	25%	2.34	2
4	Glasses	1.75	25%	2.67	6
5	Welfare payments	1.75	0%	2.97	16
6	Family counseling	2	0%	2.85	12
7	Guardianship (financial)	2	0%	2.76	9
8	Treatment for dual diagnosis	2.25	0%	3.01	18
9	SSI/SSD process	2.25	0%	3.02	19
10	Help managing money	2.25	0%	2.71	7
11	Education	2.25	0%	2.88	13
12	Discharge upgrade	2.25	0%	2.90	15
13	Emergency (immediate) shelter	2.5	0%	3.04	20
14	Long-term, permanent housing	2.5	25%	2.25	1
15	Detoxification from substances	2.5	25%	3.11	22
16	Treatment for substance abuse	2.5	75%	3.30	28
17	Women's health care	2.5	0%	3.09	21
18	AIDS/HIV testing/counseling	2.5	0%	3.38	30
19	Help with finding a job or getting employment	2.5	0%	3.00	17
20	Help with transportation	2.5	0%	2.82	11
21	Personal hygiene (shower, haircut, etc.)	2.75	0%	3.21	26
22	Clothing	2.75	0%	3.40	31
23	Services for emotional or psychiatric problems	2.75	0%	3.20	25
24	TB testing	2.75	0%	3.58	36
25	TB treatment	2.75	0%	3.45	33
26	Hepatitis C testing	2.75	0%	3.41	32
27	VA disability/pension	2.75	0%	3.33	29
28	Job training	2.75	0%	2.88	14
29	Legal assistance	2.75	0%	2.61	4
30	Food	3	0%	3.56	35
31	Halfway house or transitional living facility	3	25%	2.76	8
32	Help with medication	3	0%	3.18	24
33	Help getting needed documents or identification	3	0%	3.16	23
34	Medical services	3.25	0%	3.55	34
35	Drop-in center or day program	3.25	0%	2.77	10
36	Spiritual	3.25	0%	3.30	27

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.25	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	2.5	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.25	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.75	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.25	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.25	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.5	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.75	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	4	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.5	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	3	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	3	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	2	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.5	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2	1.84